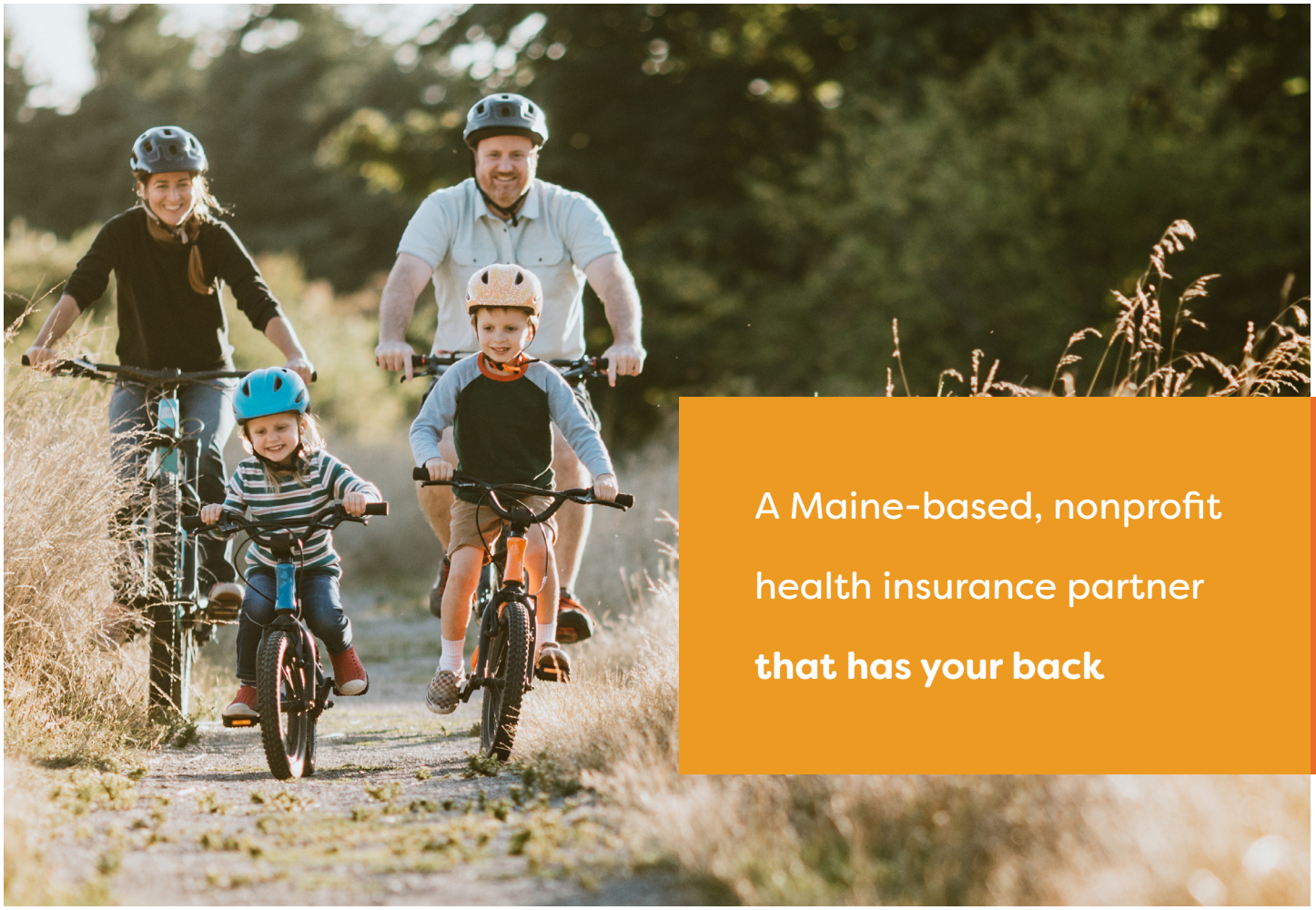

A Maine-based, nonprofit health insurance partner **that has your back**

Member Guide **2025**

COMMUNITY Health Options®

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Community Health Options Overview

Founded in 2011 and located in New Gloucester, Maine, Community Health Options is a health insurance partner that has your back. We are a local nonprofit created to serve Members, not profit off them. We strive to keep costs low, while providing the benefits you deserve.

We work with a robust network of 48,000 providers including clinicians, hospitals and pharmacies in New England, with 100% of hospitals in Maine and most in New Hampshire and many premier institutions in New England.* Our plans include PPO NE, PPO National, HMO Tiered NE, and HMO National, as well as a variety of HSA Plus options for premium savings.

Customer service is where we excel. In recent surveys, our Maine-based team of Member support and service associates earned 99% satisfaction for courtesy and respect, 97% for receipt of information needed and 98% for speed of answer.

Our team is ready to help you get the most from your plan benefits. It's healthcare insurance that feels different because it is.

We strive to keep costs low while providing the benefits you deserve.

*All Maine hospitals, except Togus VA Hospital.

Overview of Benefits

Welcome to Community Health Options! We are happy to have you as a Member. Now that you're enrolled, getting the most from your plan begins with understanding your benefits and services. We want our Members to get optimal care at the best prices, and our team is ready to help you every step of the way.

Your plan includes the following:

- 100% of the preventive care benefits required by the Affordable Care Act and the State of Maine with no cost share at in-network providers.
- First in-network primary care and behavioral healthcare visits during a plan year have no cost share on non-HSA plans.
- Access to **Firefly Health**, a virtual-first primary care team that includes a medical doctor, nurse practitioner, behavioral health specialist and health guide. Available for the same cost as traditional primary care, except on select tiered HMO plans, which have a lower site of service copay.
- Urgent care telehealth visits with $0 cost share on non-HSA plans and $0 after deductible for HSA plans via Amwell®.
- Pediatric and adult vision coverage with one exam every 12 months. Pediatric eye exams have a copay on all non-HSA plans and include coverage for frames or contacts every two years.
- $0 cost treatment for tobacco use including over-the-counter nicotine replacement therapy products such as nicotine patches, gum, lozenges and certain medications listed on our drug formulary.
- Our Chronic Illness Support Program on non-HSA plans makes it easier for Members to manage and pay for the treatment of select chronic conditions.*
- HSA plans labeled **HSA Plus** include prescription coverage for select drugs without a deductible.
- $0 cost digital wellness platform and mobile app on select plans, and unlimited personal coaching on Healthy Maine plans.
- $0 cost digital wellness platform and mobile app on select plans, with unlimited personal health coaching on Healthy Maine plans.

**Not available on Catastrophic plans.*

Overview of Benefits

MEMBERS CAN SAVE WITH A COPAY AND NO DEDUCTIBLE WHEN USING THESE SELECT PROVIDERS/SERVICES:

Excludes HSA & Catastrophic plans.

- **$0 or $5 copays** on 30-day Tier 1 preferred generic medications
- **$25 copay** for labs when you choose a **specified lab**
- **$75 copay** for X-rays at **specified locations**
- **Copays** on all plans for annual pediatric vision exams, and on select plans for adult vision exams
- **Copays** on all plans for physical, occupational and speech therapy visits as well as chiropractic and osteopathic adjustments
- **Copays** on in-network acupuncturists on select plans
- **Lower copays** on tiered plans when using a preferred provider

Finding Important Information About Your Plan

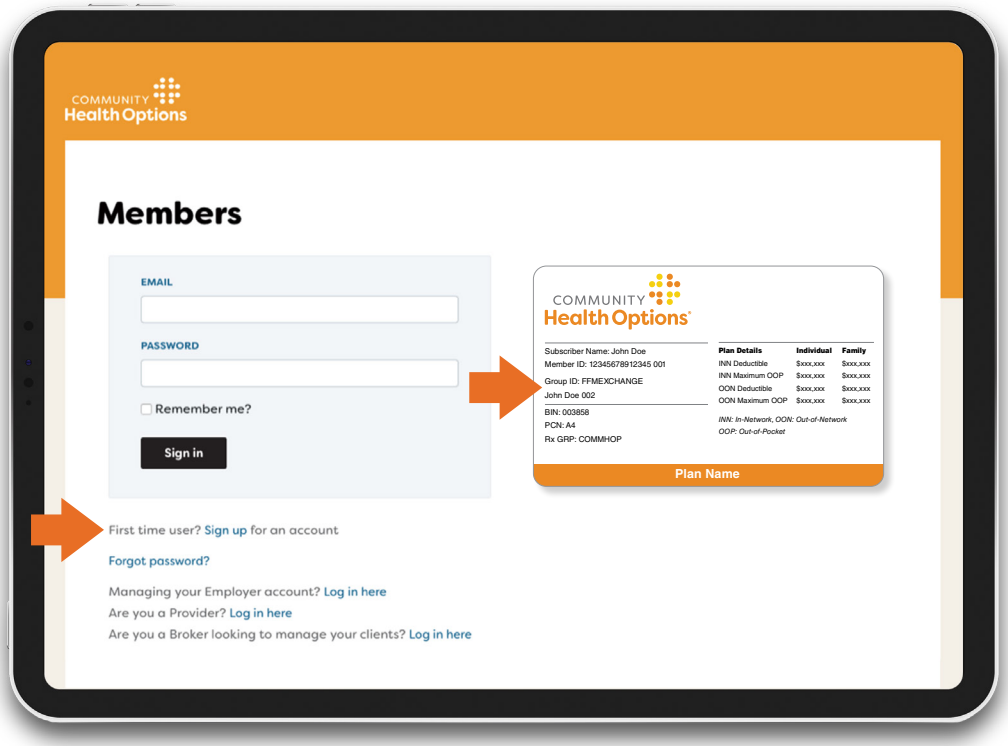
When you enrolled, you received a welcome packet with a Member ID card and instructions to set up your online portal. The Member portal provides access to plan benefits, claims, paperless delivery, primary care provider (PCP)/pediatrician (PED) selection and more. You'll also find a protected health information (PHI) release form to complete, which gives Community Health Options permission to release your personal health information to the person you choose, like a family member or caregiver. The release form is optional and only needs to be completed if you would like to designate someone else to receive PHI.

Getting Started Online: Your Portal

The portal has everything you need to get started with your new benefits plan. Setting up your **secure, personal Member portal** takes just a few minutes and gives you **24/7 online access** to your plan benefits and documents.

HERE'S HOW TO GET STARTED:

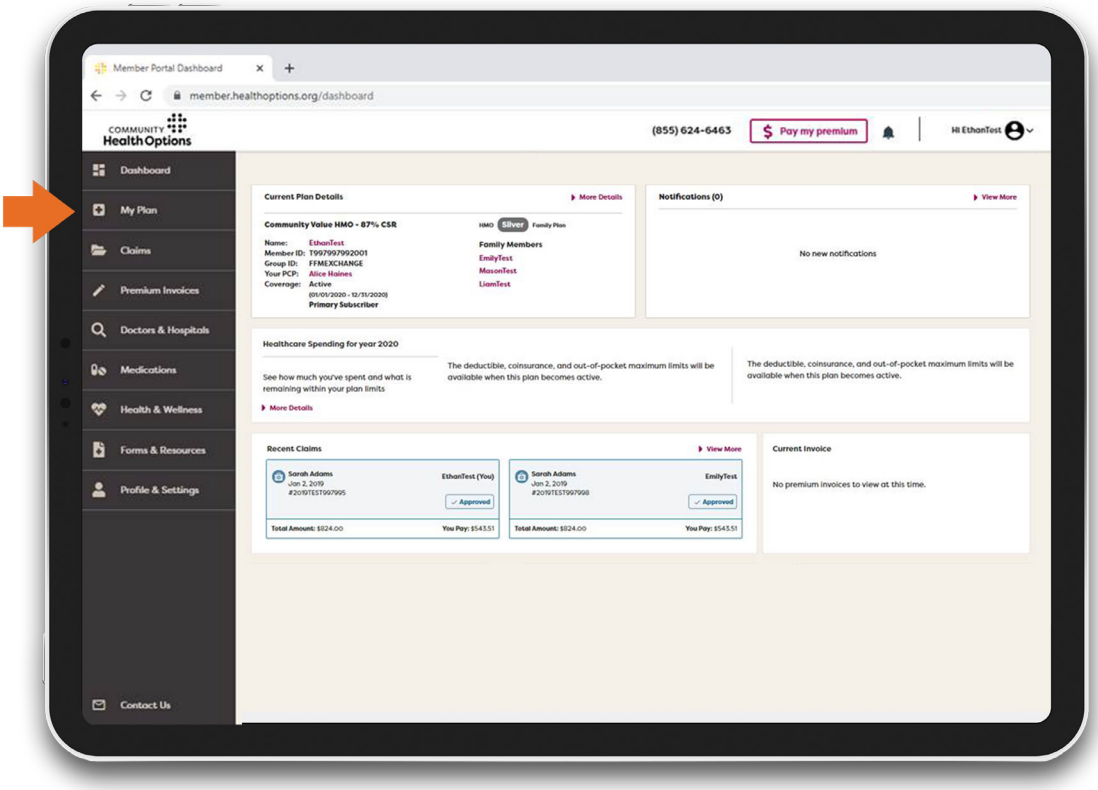
- Go to **healthoptions.org**.
- Click on **Sign In** at the far right upper corner of the screen.
- Select **Member Login**.
- Click on **First Time User? Sign up for an account**.
- At the next screen, enter your Member ID number, last name and date of birth.



Get to Know Your Member Portal

Once you set up your account, your **portal** displays your personal dashboard. From there, you can click on the menu to the left to navigate to the section you need.

Your home screen will also have quick links to items like your claims, deductible status and current notifications.



To view important plan documents, click on My Plan on the left side menu. Then, under Benefits and Coverage, click Health Plan Information:

MEMBER BENEFIT AGREEMENT

Your contract with Community Health Options, which specifies the services covered under your plan.

SUMMARY OF BENEFITS AND COVERAGE

An overview of your plan benefits, including your potential out-of-pocket costs.

SCHEDULE OF BENEFITS

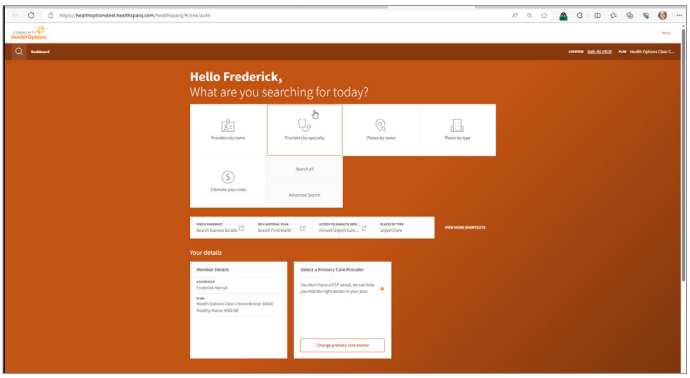
A summary of services, benefit limits and cost sharing responsibilities under your health plan.

Get to Know Your Member Portal

More ways to use your portal to manage your benefits:

FIND A PROVIDER FOR YOURSELF OR A FAMILY MEMBER

- We have a variety of options to get you the healthcare that's right for you. In your Member portal, click on **Doctors and Hospitals** to open the provider search tool. This will begin a customized search experience based on your plan.



FIND ESTIMATES FOR SERVICES

- Use the cost estimator tool to understand and compare the costs of products and planned services. On your dashboard, click **Estimate My Costs** to learn more. This will present estimated costs and a customized cost share experience based on your plan.

STAY INFORMED

- A list of preventive healthcare benefits is available in the portal, as well as access to our FAQs, resource library and blog posts. In addition, Members have access to **Healthwise**, a source for evidence-based, medically reviewed and trusted health information. Resources include articles, videos and interactive questionnaires.

Paperless delivery

Many communications are sent electronically to your Member portal, including Prior Approval letters, Explanation of Benefits and invoices. It's simple, secure and convenient. Plus, you can check your claims, see updates and more. **If you prefer to receive paper documentation, contact Member Services** at (855) 624-6463 from 8 a.m. to 6 p.m., Monday through Friday, or via email by clicking this **contact form**.

Navigating Your Network

NETWORK TYPES – What's the Difference?

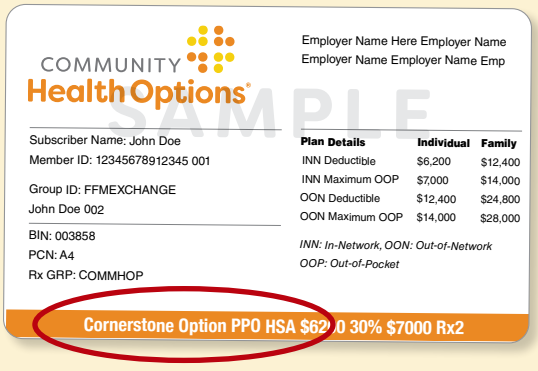
New England (NE) – Our **broad New England network** features more than 48,000 providers, including clinicians, hospitals and pharmacies in **Maine, New Hampshire, Vermont and Massachusetts**. All of our plans include the New England network.

Tiered New England (NE) – Community Health Options' tiered New England plans include access to all of the providers in our New England network and offer **reduced copays or coinsurance when you choose a preferred provider**. Our tiered plans include preferred providers throughout Maine and New England including many premier institutions.

National – For those who anticipate needing in-network care outside of our broad New England network, our **National plans include in-network access to First Health® providers across the country**.

1 Find your plan type

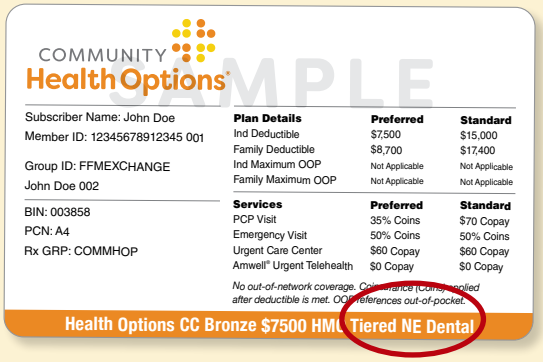
Look at your Member ID card to find your plan type, **HMO** or **PPO**. You can learn more about HMO and PPO plans on the following pages.



Plan name

2 Find your network type

Look at your Member ID card to find your network type, **New England (NE), Tiered NE** or **National**.



Network type

Find your plan and network type at the bottom of your card.

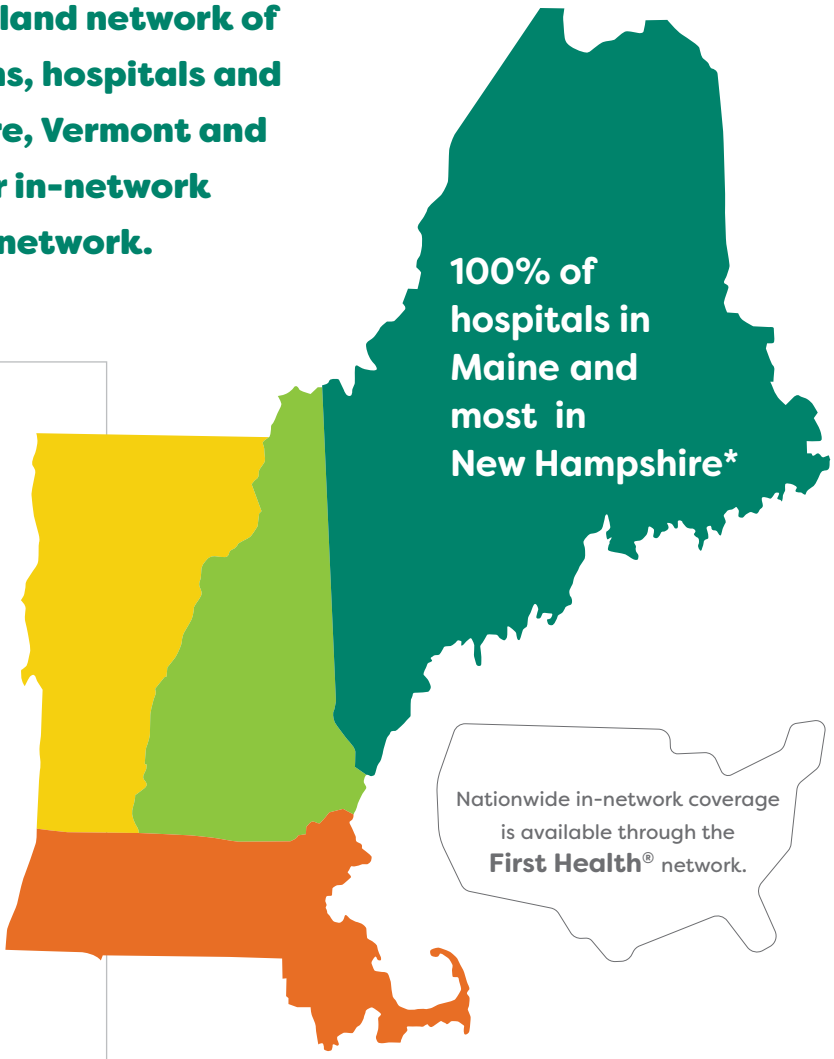
Network Providers

All plans feature our broad New England network of 48,000 providers including clinicians, hospitals and pharmacies in Maine, New Hampshire, Vermont and Massachusetts. National plans offer in-network coverage through the First Health® network.

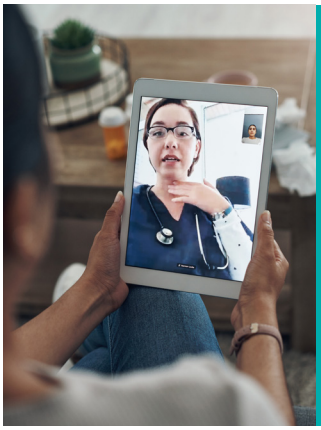
While our network comprises **100% of hospitals in Maine and most in New Hampshire**, it extends well beyond these states, including many premier institutions within New England.*

- Boston Children's Hospital
- Brigham and Women's Faulkner Hospital
- Brigham and Women's Hospital
- Dana-Farber Cancer Institute
- Dartmouth Hitchcock Hospital
- Mass Eye & Ear
- Massachusetts General Hospital
- McLean Hospital
- Newton-Wellesley Hospital
- Salem Hospital
- Spaulding Hospital
- Springfield Hospital
- Walden Behavioral Care LLC

*All Maine hospitals, except Togus VA Hospital



A complete list of in-network providers can be found in your **Member portal**.



Firefly Health: Virtual-First Primary Care

Alongside its traditional provider network, Community Health Options offers Members 18 years and older the option of using a virtual-first primary care team through Firefly Health. Members can choose a virtual primary care team that includes a medical doctor, nurse practitioner, behavioral health specialist and health guide.

To learn more, visit: fireflyhealth.com/with/cho.

Network Providers–HMO

All HMO plans offer in-network coverage through our broad New England network. HMO Tiered plans provide access to high-quality preferred providers at lower cost sharing, and HMO National plans offer national in-network coverage through the First Health® network.

MEMBER NETWORK BY GEOGRAPHIC LOCATION

Service	HMO NE	HMO Tiered NE	HMO National
Medical, Behavioral and Substance Use Disorder	Community Health Options' broad **New England network** includes providers across **ME & NH** as well as a limited number of key providers in **MA & VT**.*	Community Health Options' broad New England network has **reduced copays or coinsurance for preferred tier providers**.* A lower deductible and out-of-pocket maximum applies for preferred providers. Standard providers have a standard copay, coinsurance, deductible and out-of-pocket maximum. ***All preferred provider cost sharing is applied to both the preferred and standard out-of-pocket maximum.***	Community Health Options' broad New England network, plus **national in-network coverage**, provides access to thousands of hospitals and almost 1 million professional providers.*
	**There is no out-of-network coverage except for emergency care within the U.S., except in Small Group plans, which also have coverage for emergent conditions outside of the country.*		
Telehealth	If a provider offers telehealth services, routine in-network and out-of-network rates will apply. All plans offer in-network telehealth through Amwell® for behavioral health and urgent care, as well as primary care through Firefly Health.		
Emergency Services	All plans cover emergency services in the emergency department at the in-network level of benefits in the United States. All Small Group plans include coverage for emergent conditions outside of the country.		
Pharmacy	The Express Scripts® national pharmacy network includes most national and local pharmacies.		

Network Providers–PPO

All PPO plans have in-network access to our broad New England network, and out-of-network coverage is available with higher cost sharing. Our PPO National plans offer national in-network coverage through the First Health® network.

MEMBER NETWORK BY GEOGRAPHIC LOCATION

Service	PPO NE	PPO National
Medical, Behavioral and Substance Use Disorder	Community Health Options' broad **New England network** includes providers across **ME & NH** as well as a limited number of key providers in **MA & VT**. *For services outside of ME, NH, MA and VT, out-of-network coverage is available with higher cost sharing.**	Community Health Options' broad New England network, plus **national in-network coverage**, provides access to thousands of hospitals and almost 1 million professional providers.
	**With the exception of emergency services at the emergency department, Members may be subject to balance billing if services are rendered by an out-of-network provider. Members are responsible for ensuring Prior Approval requirements are met for out-of-network providers when required.*	
Telehealth	If a provider offers telehealth services, routine in-network and out-of-network rates will apply. All plans offer in-network telehealth through Amwell® for behavioral health and urgent care, as well as primary care through Firefly Health.	
Emergency Services	All plans cover emergency services in the emergency department at the in-network level of benefits in the United States. All Small Group plans and all Individual on/off Exchange National Gold and Silver PPO plans include coverage for emergent conditions outside of the country.	
Pharmacy	The Express Scripts® national pharmacy network includes most national and local pharmacies.	

Network Providers

Finding the Care You Need

Use this guide for tips on getting the care you need when and where you need it.

SELECTING A PRIMARY CARE PROVIDER (PCP) OR PEDIATRICIAN (PED)

You can find and select a PCP or PED in your Member portal for you and members of your family. To make sure you find a provider who fits your needs:

- Ask the PCP/PED about office hours and whom to contact after hours.
- If you are on a tiered plan, check to be sure the PCP/PED has a tiered designation.
- Check how long it will take to obtain an appointment, and whether the provider will speak with you over the phone.
- Ask how long a typical waiting room time is.
- If you need help selecting a PCP/PED, contact Member Services at (855) 624-6463.
- For easy access, consider selecting an in-network virtual primary care team at Firefly Health. Learn more by visiting: **fireflyhealth.com/with/cho**.

BEFORE YOUR PCP VISIT

- Review your Summary of Benefits & Coverage to confirm your cost share for a PCP visit.
- Be prepared to pay on the day of your appointment.
- Preventive care visits with in-network PCP/PED providers are available at $0 cost share. Services covered are based on the recommendations listed at **healthcare.gov**. Note: Tests and additional services provided during the visit may be subject to routine cost sharing.

Network Providers

Site of Service

RECEIVING CARE AT SPECIFIED LOCATIONS CAN SAVE YOU MONEY

You pay less for your care by choosing specific sites for lab tests and X-rays. Members have a copay with no deductible at these specified locations, rather than paying coinsurance after the deductible. HSA Members also have a copay once their deductible is met.

You can find site-of-service locations by visiting the Community Health Options directory at **healthoptions.org** or clicking the links below.

$25 copay on labs at specified locations. Click here.

$75 copay on X-rays at specified locations. Click here.

On select plans, Members also save when they visit specified free-standing urgent care locations or use Firefly Health for primary care services. Visit the Community Health Options directory for more information.**

**Not available on Catastrophic plans.*

***Members on Silver $4200 HMO Tiered NE and Bronze $7500 HMO Tiered plans pay lower copays for services though Firefly Health primary care and for care received at specified urgent care locations. View your plan details for more information.*

WHERE TO GO FOR CARE

Primary Care

Healthcare Service	When & Why to Choose This Option	Typical Expense
Primary Care Provider (PCP)/ Pediatrician (PED) The doctor, physician assistant or nurse practitioner you chose when your Community Health Options coverage began. This includes virtual primary care through Firefly Health. **Note:** If you are on a tiered plan, make sure you select a preferred provider for reduced costs.	**Call or visit your PCP/PED for:** • Regular well checks • Preventive services • Minor skin conditions • Cold- and flu-related symptoms • Referrals to specialists • Assessing medical conditions or concerns • Vaccinations • General health management of chronic conditions	$
Walk-in Primary Care Service A walk-in clinic is a healthcare facility that provides convenient basic medical care and can usually be found near pharmacies or retail stores. These services are generally associated with a PCP practice and have extended hours and walk-in service.	**Use walk-in primary care when you need quick care for non-life-threatening conditions.** • Sprains • Minor injuries that require stitches • Minor burns • Minor broken bones • Minor infections • Cold, flu, strep symptoms • Respiratory infections	$-$$ Costs may vary but will generally be lower than in a hospital emergency department.

Network Providers

WHERE TO GO FOR CARE

Urgent Care

Healthcare Service	When & Why to Choose This Option	Typical Expense
Amwell® Urgent Care Telehealth Visits online or over the phone with a clinically licensed urgent care provider.	**Log in to Amwell® Urgent Care when you need quick care for non-life-threatening conditions.** • Headaches • Minor burns • Minor infections • Cold, flu, strep symptoms • Respiratory infections	$0 **$0 after deductible for HSA plans.**
Urgent Care These are stand-alone, walk-in clinics. For a list of in-network urgent care locations, visit the provider directory in your Member portal. An easy, printable reference list may also be found in your portal, under Forms and Resources.	**Go to an urgent care center when you need quick care for non-life-threatening conditions.** • Sprains • Minor injuries that require stitches • Minor burns • Minor broken bones • Minor infections • Cold, flu, strep symptoms • Respiratory infections	$ $
Emergency Department (ED) at a hospital	**Go to the ED or call 911 for serious, life-threatening injuries or conditions:** • Large open wounds • Heavy bleeding • Chest pains • Sudden weakness or trouble talking • Major burns • Severe head injuries • Major broken bones • Difficulty breathing	$ $ $

Preventive Care

Your plan covers many preventive healthcare services, including screenings, checkups and counseling at no cost. You are not required to wait 365 calendar days between visits to see your provider for annual preventive wellness care and checkups. These annual visits reset based on the date your coverage began, not the date of your last appointment. While it is best to schedule your yearly preventive services approximately 12 months apart to get the maximum benefit, you have some flexibility with appointment dates—peace of mind knowing your care is on your schedule. Refer to your plan documents for details on all covered preventive services.

Take advantage of **adult and pediatric preventive care** benefits, outlined by state and federal laws, which are covered at no cost when performed by in-network providers.

Full coverage for a yearly **influenza/flu vaccination** is available for adult and pediatric Members when administered by an in-network provider (doctor or pharmacy).

No cost share for **COVID-19** vaccinations or provider-administered COVID-19 testing/screening.

Preventive screenings often identify diseases or medical conditions before any signs or symptoms are present, enabling early diagnosis of health problems. Preventive screenings do not include tests or services to monitor or manage a condition or disease once it has been diagnosed.

Preventive screening colonoscopies with no cost share for Members age 45 and older. Preventive health screening colonoscopies have no deductible, coinsurance or copay.

Preventive counseling usually occurs when a person has been identified (but not yet diagnosed) as being at risk for a specific disease or medical condition at a preventive screening. Preventive counseling and intervention are intended to provide basic information about a medical condition and help you develop the skills to manage your health.

Preventive Care

Diagnostic versus Preventive Services

A **diagnostic** service is performed to evaluate and determine treatment for **new symptoms** or to monitor **existing conditions**. Diagnostic services help the provider diagnose an illness and offer an opportunity for the provider to discuss the best course of treatment. These services are subject to routine cost sharing.

Preventive services include screenings that are provided when you or your family member are symptom-free and have no reason to believe you might be unhealthy. Many times, preventive screenings are recommended for a specific population and are provided as part of a routine physical or check-up. Preventive screenings outlined in the Affordable Care Act (ACA) at **healthcare.gov** are covered at no cost to you.

Some services performed during or related to an annual preventive exam, such as lab tests or diagnostic procedures, may not be covered as a preventive service and are subject to routine cost sharing.

If the provider recommends a service or test, it's helpful to ask the provider:

- What is the test for?
- Why is this service needed?
- Are there any alternatives?
- What are the possible complications?
- Is there an in-network option for this service?

If you are in a tiered network plan and additional services or tests are recommended, be sure to check for an in-network provider. If you have questions about how services are covered, contact Member Services at (855) 624-6463, from 8 a.m. to 6 p.m., Monday through Friday, or via email by clicking this **contact form**.

Preventive Care

Commonly Asked Preventive Services Questions

Where can I find a list of preventive services covered with no out-of-pocket cost?

Visit **healthcare.gov** to learn more about preventive services for adults, children or women.* In addition, the following services are covered:

- Routine immunizations for children, adolescents and adults recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices; and
- Services for women, infants, children and adolescents that are further outlined by the Health Resources and Services Administration.

Which immunizations are covered as a preventive service?

Routine immunizations listed on the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices website are covered for children, adolescents and adults.

- Most childhood (age 18 or younger) vaccinations, including HPV for boys and girls, are covered. A list of **child and adolescent routine immunizations** (age 18 or younger) may be found **here**.
- A list of **adult routine immunizations** may be found **here**.

Are lab tests covered as a preventive service?

Generally, routine lab tests, such as a complete blood count (CBC), Lyme disease, Vitamin D, or thyroid tests are not covered as preventive services, and they are subject to routine cost sharing. Screening tests, such as some cholesterol and blood sugar tests, are covered with no cost share based on age and certain risk factors and provided the blood test is not monitoring a diagnosed condition. Lab tests included as preventive services can be found at **healthcare.gov**, or by visiting one of the resources listed below:

- View the list of Preventive Care Benefits for women by clicking **here**.
- Visit the Preventive Care Benefits for children from healthcare.gov by clicking **here**.
- Visit the Adult Preventive Services benefits by clicking **here**.

**New guidelines may be published. The timing of no-cost coverage is applied to a future date. For example, a recommended service release date in March 2025 may not be covered as a preventive service until 2027.*

Wellness Benefits

For easy access to these resources and services, set up your Member portal at **healthoptions.org**.

Primary Care and Behavioral Health

There is no cost for your first in-network behavioral health visit or your first primary care visit during a plan year. (Members on an HSA plan have a copay after the deductible.) Tests and services provided during your primary care visit may be subject to standard cost sharing. Your plan covers many preventive healthcare services, including screenings, checkups and counseling at no cost. For more information about preventive wellness, please refer to the Preventive Care section of this guide or your plan documents.

Virtual Care Options

A provider visit can be just a click away, and virtual care service makes it easy for you to schedule appointments and access urgent care, all from the comfort of your home.

- If your provider offers telehealth services, the visit will have the same plan coverage as in-network or out-of-network provider office visits.
- All Members 18 years and older can access virtual primary care through **Firefly Health**, which offers a virtual primary care team that includes a medical doctor, nurse practitioner, behavioral health specialist and health guide. To learn more, visit **fireflyhealth.com/with/cho**. Appointments will have the same plan coverage as in-network primary care office visits. Our Health Options Clear Choice $4200 HMO Tiered NE and Health Options Clear Choice $7500 HMO Tiered NE plans have a site-of-service copay of $25 for Firefly Health primary care provider visits.
- All plans include telehealth for urgent care, psychiatry and counseling/therapy through **Amwell**®. One-time and continued behavioral healthcare visits can be easily managed through the Amwell patient portal. Urgent care telehealth is available 24/7, providing access to treatment whenever it's needed. Additionally, there is no cost share for Amwell urgent care telehealth visits on non-HSA plans and $0 after deductible for HSA plans.

Wellness Benefits

Chiropractic and Osteopathic Adjustment Coverage

All plans include coverage for chiropractic and osteopathic adjustments. You'll find detailed information in your plan documents.

Acupuncture

Select non-HSA plans, including Healthy Maine plans, have coverage for acupuncture services with a copay for in-network providers and up to $50 reimbursement for out-of-network providers. HSA Members with this benefit can get in and out-of-network reimbursement up to $50 per visit with no deductible. You'll find detailed information in your plan documents.

Vision

All plans offer adult and pediatric vision coverage including one eye exam every 12-month calendar year. On non-HSA plans, pediatric visits have a copay, and on certain plans, adult visits also have a copay. All plans include pediatric coverage for glasses and contacts (every 24-month calendar period) with varying coinsurance, copayment and deductible requirements.

Oral Health

Community Health Options partners with Northeast Delta Dental® to provide dental coverage for pediatric Members on select plans. A special, low dental deductible applies and covered out-of-pocket dental expenses are applied to medical out-of-pocket expenses. Detailed information is available within your plan documents.

Wellness Programs & Tools

Our programs and tools are designed to help you reach your wellness goals. Whether you are already on your path to better health or just getting started, we'll be there every step of the way.

Health Education

Healthwise® provides evidence-based, medically reviewed health information you can trust. This education platform includes a symptom checker, decision support tools, and thousands of articles and videos with up-to-date health information. Use this education platform to gain knowledge and stay informed on topics that matter to you. You can access Healthwise in your Member portal.

Wellness Platform and App

On select plans we partner with WellRight® to provide a digital wellness platform and mobile app at no cost to Members 18 years and older. Benefits include gamified wellness challenges, integration with wearable devices, and a comprehensive health risk assessment. You can access your account through the Health and Wellness tab in the Member portal, by downloading the WellRight app or logging on to **healthoptions.wellright.com**. When you download the mobile app, you will need to enter the company code "healthoptions" to begin your personalized experience.

Unlimited Personalized Health Coaching

Our Healthy Maine plans include unlimited personalized health coaching for Members 18 years and older at no cost through our wellness platform. Trained health coaches can meet over the telephone, through text, video chat or email and can assist with the following:

- Personalized Nutrition
- Financial Fitness
- Tobacco Treatment
- Physical Activity
- Prenatal Wellness
- Stress Management
- Weight Management
- Heart Health
- And More

Treatment for Tobacco Use

Our Tobacco Cessation Program offers an enhanced benefit for over-the-counter nicotine replacement therapy products, including nicotine patches, gum, lozenges and certain FDA-approved medications listed on our drug formulary, and is available at $0 cost share. Our care managers are available to support you along your journey to becoming tobacco free. Call Member Services at (855) 624-6463 to get started.

Care Management

Our care managers are specially trained to help you with medical services you need and to assist you with saving money on prescribed medications. Programs are available to aid our Members through a broad spectrum of services. These include transitions of care such as hospital to home, disease management, chronic condition management, cancer care, pregnancy/post-partum and behavioral healthcare. Our team partners with a range of local agencies to offer community support.

Chronic Illness Support Program

All non-HSA plans include the Chronic Illness Support Program (CISP) designed to improve the health and well-being of Members with asthma, coronary artery disease, chronic obstructive pulmonary disease, diabetes and hypertension.*

Members who manage their conditions through in-network office visits can save on routine care. Additionally, Members can save on CISP designated medications when ordering through the Express Scripts (ESI) mail order pharmacy.

BENEFITS INCLUDE

- **Select Tier 1 Generic Medications** at $0 with ESI mail order.
- **Select Tier 2 and 3 Medications** at 50% cost share reduction with ESI mail order.
- **Select Medical Services** at $0 when performed by a network provider (see chart below).

CHRONIC ILLNESS SUPPORT PROGRAM (CISP) MEDICAL SERVICES

Asthma	Coronary Artery Disease (CAD)	Chronic Obstructive Pulmonary Disease (COPD)	Diabetes	Hypertension
Office visits to the following providers: • Primary Care Provider, Pulmonologist, Allergist for routine management of asthma • Palliative care conversations with provider to discuss chronic condition treatment • Immunotherapy for allergen sensitization **Also covered:** • Inhaler adjuncts (e.g., holding chamber/spacer) through mail order • Pulmonary function tests • Allergy sensitivity testing • Asthma education • Targeted laboratory tests for the routine management of asthma	**Office visits to the following providers:** • Primary Care Provider, Cardiologist for routine management of CAD • Palliative care conversations with provider to discuss chronic condition treatment **Also covered:** • Electrocardiogram (ECG) • Nutritional counseling, up to twelve (12) visits per year • Cardiac rehabilitation and associated exercise programs are covered at 50% cost share reduction • Targeted laboratory tests for the routine management of CAD	**Office visits to the following providers:** • Primary Care Provider, Pulmonologist for routine management of COPD • Palliative care conversations with provider to discuss chronic condition treatment **Also covered:** • Inhaler adjuncts (e.g., holding chamber/spacer) through mail order • Pulmonary function tests • Home oxygen therapy assessment • Pulmonary rehabilitation and associated exercise program are covered at 50% cost share reduction • Targeted laboratory tests for the routine management of COPD **Note: Oxygen delivery and supplies are subject to routine coverage.**	**Office visits to the following providers:** • Primary Care Provider, Endocrinologist, Podiatrist, Optometrist/ Ophthalmologist for routine management of diabetes • Palliative care conversations with provider to discuss chronic condition treatment **Also covered:** • Nutritional counseling, up to twelve (12) visits per year • Diabetes education with a certified diabetes educator • Targeted laboratory tests for the routine management of diabetes **Diabetic supplies specified on the formulary and dispensed via ESI mail order are covered at $0 cost share:** • One glucometer per year • Glucose test strips: up to 150 strips every 30 days or 450 strips every 90 days • Monthly FreeStyle Libre Continuous Glucose Monitoring system sensors **Note: Aside from FreeStyle Libre, all other continuous glucose monitors, insulin pumps, and associated supplies are subject to routine coverage.**	**Office visits to the following providers:** • Primary Care Provider for routine management of hypertension • Cardiologist and Nephrologist for consultation and routine hypertension management • Palliative care conversations with provider to discuss chronic condition treatment **Also covered:** • Nutritional counseling, up to twelve (12) visits per year • Targeted laboratory tests for the routine management of hypertension

**Not available on HSA plans or Catastrophic plans.*

Pharmacy Management

Our in-house pharmacists support the development of a competitive and cost-effective prescription drug formulary in partnership with Express Scripts®, a Pharmacy Benefit Manager. For more information on copays by Tier, see plan details at **healthoptions.org**.

PRESCRIPTION DRUG FORMULARY TIERS	
TIER 1	Preferred Generics
TIER 2	Generics
TIER 3	Preferred Brand
TIER 4	Non-Preferred Brand
TIER 5	Specialty

Prescription Programs

We offer you several ways to make it easier to take prescribed medications. The **Price Assure Program** automatically saves you money on generic medications when you take your prescriptions to in-network pharmacies that also accept GoodRx®. By using the Express Scripts pharmacy card, you get any possible savings while the cost applies to your deductible, accumulator and out-of-pocket costs. Through the **Medication Synchronization Program**, our Pharmacy team works directly with those who are prescribed three or more maintenance medications to coordinate refills to be picked up at the same time—eliminating multiple trips to the pharmacy. Additionally, through our **ScriptSaver Program**, our Pharmacy team works with you, your provider and the pharmacy to find cost-saving opportunities.

Special Insulin Provision

Members requiring insulin will have a cost share not to exceed **$35 for up to a 30-day supply on all plans**.

ACA Preventive Drug Coverage

Under the Affordable Care Act (ACA), pharmacy benefits cover certain categories of preventive care drugs and products at 100% in all plans when ACA preventive care requirements are met. This means there is no cost share (deductible, copayment or coinsurance). These drugs will be designated with ACA on the formulary. To view the ACA-included medications, visit the Member portal or **click here** to go to the formulary.

Low Copay Preferred Generic Medications

All non-HSA plans offer Tier 1 medications at **$0 or $5 copay for 30 days**.* Ninety days of medication is available for a **$10 copay** if obtained through mail order with Express Scripts. HSA Plus plans offer select preventive medications with no deductible, but cost shares apply.

HSA Plus Enhanced Preventive Drug Coverage

HSA Plus plans include a carefully curated list containing medications to help prevent the development of and reduce the risk of complications due to chronic conditions and illnesses. These prescription drugs, identified on the formulary with an HSA+ notation, bypass the deductible and require you to pay only the applicable coinsurance or copayment amounts. To view the HSA+ medications, visit the Member portal or **click here** to go to the formulary.

**Not available on Catastrophic plans.*

Pharmacy Management

Pharmacy Benefit Manager

The Express Scripts® portal gives you a high degree of control over your prescription orders and costs with medication comparisons and suggestions for lower cost options. **Importantly, our Pharmacy team found that 90% of prescriptions filled for our Members were generics—saving them money and helping them to stay on schedule with their medications.*** For more information on the drug formulary, visit **healthoptions.org**.

Our pharmacy benefit manager, Express Scripts, offers a portal that gives Members a **high degree of control over their prescription ordering and costs.**

In a recent prescription drug utilization review, our team found that **90% of filled Member prescriptions were for generics**, helping our Members save money.

**As of 1st quarter 2024*

Pharmacy Management

Getting Started: Filling Prescriptions

We want Members to benefit from the best prices for prescriptions and over-the-counter medicines ordered by a provider. Our pharmacy network gives you access to retail pharmacies throughout the country, as well as access to mail order through Express Scripts®.

Benefits of mail orders:

- You can fill most prescriptions for maintenance medications three months at a time through the ESI Extended Payment Program (EPP), which allows you to divide the cost over three payments.*
- For medications subject to a 30-day copay, you pay only two copays for a 90-day supply.*
- You can order Chronic Illness Support Program qualified medications through mail order at the CISP discount.
- You can speak directly with an Express Scripts pharmacist when you have questions or concerns about your medications.

For more information, go to **Express Scripts** to set up your account. It's as easy as clicking on the **Register** button and following the prompts.

*Certain limitations apply.

ACTIVATE YOUR EXPRESS SCRIPTS ONLINE PORTAL

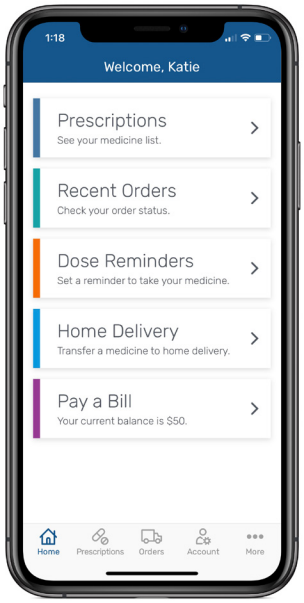
- Express Scripts, our pharmacy benefits manager, provides help with prescription-related information and services through its own website.
- Register with Express Scripts by going to the portal's Medications section and clicking **Get started / Log in.**

Express Scripts Mobile App

STAY ON TRACK WHILE YOU ARE ON THE GO

The Express Scripts mobile app helps you manage your personal medication information—anytime, anywhere. You can order refills and renewals, check order status, transfer to mail order, price medications, and more.

Just search for "Express Scripts" and download the app from your app store. Log in with your username and password. First-time visitors must register using their Member ID number or Social Security number. You can also use your device's touch or face ID authentication to log in, if available.



Pharmacy Management

Specialty Pharmacy

Community Health Options partners with Accredo® to manage specialty medication needs.

- Accredo mail order offers medications prescribed to treat chronic and complex conditions.
- The Accredo team is available to help you get the best possible financial coverage for specialty medications and help Members understand the available options.
- Accredo benefit specialists help Members navigate insurance coverage, approvals and eligibility.
- We know specialty medications are expensive. Many drug manufacturers and community organizations offer financial assistance programs. For more information, go to **Accredo** or call (877) 895-9697.

Pharmacy Success Story

When severe winter storms caused shipping delays, a Member with multiple sclerosis was unable to get her medication. She called Member Services, terrified of a relapse. Our pharmacist found a local supply for $250, but reduced the Member's cost to $0 with a manufacturer's coupon.

Medical and Care Management

Medical Management

Our Medical Management team includes a variety of healthcare professionals who work together to remove barriers, making it easier for Members to obtain medications and durable medical equipment. These specialists serve as a connection between Members and providers to assist with communication and education.

Care Management

MANAGING SERIOUS ILLNESS OR INJURY

When it comes to serious illness, our nationally accredited complex care management programs provide compassionate, personalized support for metastatic cancers, pediatric intensive care and transplants. Assistance includes contacting providers, in-patient facilities and national transplant networks.

- Members with special care needs who are transitioning from a prior health insurance carrier will be paired with a Complex Care Manager to ensure a seamless transition.
- Members identified with high health risks have access to complex care management resources.

HOSPITAL READMISSION PREVENTION PROGRAM

With a **69% reduction** in readmission rate (2018–2023), we are working hard to help Members get well while reducing costs associated with readmission to the hospital. In-house specialists coordinate with Care Management to assist Members at high risk of readmission. Examples include partnering with home health agencies, community agency care teams and other local agencies.

Medical and Care Management

Care Management (continued)

INFUSION SITE OF CARE PROGRAM

Our voluntary **Infusion Site of Care Program** has saved millions of dollars for our Members by offering the ability to transition certain intravenous (IV) medications and infusions to a preferred site of care, including a Member's own home. This program delivers a meaningful choice with **reduced cost shares** and **increased quality of life**. In addition to these savings, Members will be offered a monetary incentive payment for select medications when receiving infusions from a preferred Site of Care provider.

SUBSTANCE USE DISORDER

Our Care Management team works closely with Members and dependents who are seeking treatment for substance use disorder. Our team provides **high-quality, cost-effective and convenient in-network program options**. This includes transitional support after discharge from an inpatient behavioral health or substance use facility.

We work every day to keep costs low and give Members the healthcare benefits they **expect and deserve.**

Care Management Success Story

A Northern Maine couple chose to have their premature baby boy at a city hospital several hours away so they could get the specialized care their baby needed. But the commute put an incredible strain on Mom and Dad and their two other children. Once the baby was doing well, care managers worked with the family and providers to move him to a hospital closer to home and transfer his care to the same local pediatrician who would hopefully care for him through his childhood.

Member Services

Member Service Excellence

Our Maine-based, in-house customer service representatives work from Lewiston to Fort Kent, and earn high satisfaction rates from our community. When you call our team, you can be assured that you will get the information you need. The Member Services team is led by two guiding principles:

PROMISES DELIVERED

When we make a promise to do something, we keep that promise. We always have your back. We are committed to Members' satisfaction every day. In recent post-call surveys with our Members, we earned **99% satisfaction for courtesy and respect, 97% for receipt of information needed and 98% for speed of answer**.

WE DON'T ISSUE HOMEWORK

If a matter requires follow-up or if more information is needed, we will advocate for you to get the information, or be sure to connect you with the right people.

MEMBER SURVEY RESULTS:

99%	satisfaction for courtesy and respect
97%	satisfaction for receipt of information needed
98%	satisfaction for speed of answer

"I am a subscriber AND a provider. As a psychotherapist, I regularly call Community Health Options and have uniformly excellent experiences. Their customer service is outstanding. There are very short hold times—if any—and the customer service folks are knowledgeable, efficient, polite and kind. In the last 12 months, I have called Maine Community Health Options 8 or 9 times and always had my questions answered politely and promptly. Proud that I live in Maine and have a GREAT Maine company that serves me professionally and personally."

Frequently Asked Questions

When will I get my first invoice?

If you have enrolled in an individual policy, we will mail your first invoice to you around the tenth business day of the month, and subsequent invoices will be sent electronically each month thereafter on the same schedule. Invoices are payable by the first of the following month. If you are on a group policy, contact your employer for information on your premium payment.

Individual policy Members can make a payment by:

1. Logging into your Member portal and clicking the **Pay my premium** button.
2. Calling the automated payment line at (844) 722-6243.
    - For debit or credit card payments, please have your Member ID, debit or credit card account number, security code and expiration date ready.
    - For payments by check, please have your Member ID, bank routing number and account number ready.
3. Mailing a check to **Community Health Options, PO Box 986529, Boston, MA 02298-6529**. Please include your invoice coupon and policy number on the check or money order.

What is a Preferred Provider Organization (PPO)?

PPO stands for preferred provider organization. These plans provide coverage for both in-network and out-of-network services and providers.

- PPOs require you to select an in-network primary care provider (PCP) who has a contracted agreement with Community Health Options. In-network means we have a contract that states these providers will accept payment on the contracted dollar amount instead of their usual charges. Network providers cannot bill you for the difference between their charged rate and their contracted rate.
- PPOs **do not** require you to get a PCP referral for specialist care. However, many specialists DO require referrals, even if our plans do not.
- If you choose out-of-network services and providers, these costs are applied to a separate deductible and out-of-pocket maximum than your in-network services and providers. Costs are paid at the "usual and customary" rate. If the costs exceed this amount, you may be billed for the difference.

What is a Health Maintenance Organization (HMO)?

HMO and PPO plans both require that you select a primary care provider (PCP) from our network, but HMO plans generally come with lower premiums and have fewer provider choices. With an HMO:

- Your PCP coordinates in-network care.
- You have no out-of-network coverage.

Frequently Asked Questions

What is an HMO Tiered plan?

Tiered HMO plans provide access to Community Health Options' broad New England network. Providers and facilities that meet or exceed our quality, price and efficiency standards are "preferred," and other in-network providers are "standard." The preferred tier offers high quality and lower cost share to you including lower copays, coinsurance, deductible and out-of-pocket maximum. Tiered plan Members can continue receiving care from a standard tier provider with a standard cost sharing. These plans do not have out-of-network coverage, except for emergency services within the U.S.

What is a Health Savings Account (HSA)?

An HSA, or Health Savings Account, is a specialized account for individuals with qualifying high deductible health plans (HDHPs). These accounts are a tax-free way for Members to pay for qualified medical expenses. Medical payments made from an HSA are tax-free. Interest earned by an HSA is tax-free. HSAs have no "use it or lose it" restriction. If you don't use funds, they remain in your HSA each year, and your money continues to earn tax-free interest. It's important to recognize that only specific HDHPs are compatible with HSAs, and not all plans with high deductibles meet the requirements. For detailed guidance on whether your plan qualifies and to understand the associated tax benefits, it is recommended to seek advice from a tax professional.

What is a Primary Care Provider (PCP)?

A PCP can be an in-network physician, physician assistant or specialist in internal medicine, family practice, general practice, pediatrics, obstetrics or gynecology. PCPs can also be an advanced practice registered nurse or certified midwife licensed by the applicable state nursing board. Your PCP is a partner in your healthcare who advises you and provides treatment on a range of health-related issues. He or she may assist you in your interactions with specialists.

What happens if my healthcare eligibility changes?

If you experience a qualifying event (such as moving or having a baby), you may qualify for a Special Enrollment Period, which is time outside of the annual Open Enrollment when you or a family member can sign up for health insurance. The enrollment window is up to 60 days after the qualifying event and for some events up to 60 days prior. If you have questions, contact Member Services at (855) 624-6463.

Frequently Asked Questions

Which life events could affect my health insurance coverage?

The following circumstances may trigger a Special Enrollment Period when you can change your coverage:

1. Loss of other qualifying coverage
2. Change in household size
3. Changes in primary place of living
4. Change in eligibility for financial help
5. Enrollment or plan error

Other Qualifying Changes:

1. Being determined ineligible for Medicaid or CHIP
2. Exceptional circumstances
3. Being a survivor of domestic violence or abuse or spousal abandonment
4. AmeriCorps service membership

What does in-network and out-of-network mean?

- **Our in-network providers** have signed a contract with Community Health Options or the First Health® network to accept payment on a lower contracted dollar amount instead of their usual charges. In-network providers cannot bill you for the difference between their charged rate and their contracted rate.
- **Our out-of-network providers** have no contractual working relationship with Community Health Options. However, you may still receive care from these out-of-network providers if you have a PPO plan. If you see a doctor out-of-network, Community Health Options will cover the visit at the out-of-network rate. It is the Member's responsibility to obtain Prior Approval for services provided by an out-of-network provider. In certain circumstances, the difference between the amount the provider bills you and the amount your benefits pay is defined as balance billing. This differential amount would be at your cost and does not apply to your maximum out-of-pocket expense per plan guidelines. As a reminder, HMO plans do not offer out-of-network benefits.

Note: First Health Network is available only on select plans. Refer to plan documents and your ID card to determine availability

What happens if I need to use my plan while out of the country?

All plans cover emergency services in the emergency department at the in-network level of benefits in the United States. All Individual National Gold and Silver PPO plans, and all Small Group plans include coverage to care for emergent conditions outside the country. If you plan to travel outside the U.S., including Canada, please check your plan benefits and consider supplemental travel insurance.

Frequently Asked Questions

What is a prescription drug formulary?

The formulary is a list of covered prescription medicines deemed safe and effective. All plans include a carefully created prescription drug formulary that emphasizes the prevention of chronic conditions and illnesses. Our formulary includes drug designations to indicate whether the drug requires Prior Authorization (PA), is covered under the Chronic Illness Support Program (CISP) or the Affordable Care Act (ACA), and other benefits offered on many Community Health Options plans. To download our prescription Drug Formulary, click **here**.

Note: Formulary changes can occur throughout the year, but the majority occur on or near January 1 and July 1. Members are notified when one of their medications is being removed from the formulary.

What are covered vs. non-covered services?

Covered benefits are health services that your insurance policy pays for. You may be required to pay copays, coinsurance or deductibles. **Non-covered benefits or exclusions are those that an insurance plan does not pay for.** For more information about covered services, please read your Member Benefit Agreement.

What do out-of-pocket costs include?

Out-of-pocket costs, also known as cost sharing, vary slightly according to your plan but in general, copays, deductibles and coinsurance are your out-of-pocket costs. Non-covered services are not included in out-of-pocket costs.

What is a copayment (copay)?

A copayment is a fixed amount that you pay for a covered healthcare service, usually when you receive the service. Your copay is determined by your plan. Unless specified on your Schedule of Benefits, the deductible does not have to be met for the application of a copayment. Copayments do not count toward your deductible or out-of-pocket maximum unless otherwise stated on your Schedule of Benefits.

What is an Explanation of Benefits?

An Explanation of Benefits (EOB) is a statement we will send you to explain what medical treatments and/or services were paid for on your behalf. EOBs are sent upon the completed processing of a medical claim. An EOB will explain the benefit plan payment and your financial responsibility pursuant to the terms of the policy. If you need assistance reading or interpreting your EOB, please contact Member Services at (855) 624-6463.

What is a deductible?

The deductible is the amount you pay for certain covered services before your plan pays benefits. **Payments for services that apply to the deductible are applied toward your deductible until the total is met.** If you have a family plan, you may collectively meet a family deductible, at which point all individual deductibles are considered met. You can find more information about your deductibles in the Member portal.

Frequently Asked Questions

How do I calculate my coinsurance?

The coinsurance amount you owe is based on a percentage of the allowed amount on a claim. You and the plan each pay a certain percentage, which together equals 100%. This normally applies once a deductible has been satisfied for many covered services. Please consult your plan's Schedule of Benefits for specific cost sharing information.

How are claims submitted?

Plan providers will file claims directly with the plan. Members may need to submit a claim for reimbursement for services from a non-plan provider.

Do I need Prior Approval for services?

Certain services and prescriptions require review and approval from our Utilization Management team or from our partner, Express Scripts Inc.®, before allowing coverage by the plan. If you receive care from an in-network provider, your provider is responsible for obtaining these approvals. If you receive care from an out-of-network provider, it is your responsibility to obtain these approvals. More information about Prior Approvals for medical, behavioral health, and prescription benefits is available **here**, or contact our Member Services team for assistance.

More questions?

Call Member Services with your questions at (855) 624-6463, from 8 a.m. to 6 p.m., Monday through Friday, or email the team using our **contact form**.

Community Health Options is an innovative, Maine-based nonprofit health insurance partner **that has your back.**

Our team of Maine-based Member Services Associates earns high marks for answering questions with courtesy, respect and accuracy of information. Give them a call with your questions at (855) 624-6463, from 8 a.m. to 6 p.m., Monday through Friday.

COMMUNITY Health Options®

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For more detailed information about our health plans or to review our Provider Directory, Drug Formulary or Privacy Notice, please visit our website at **healthoptions.org**. If you do not have access to a computer or internet services, please call (855) 624-6463.